STATE VETERANS HOME PLAN OF CORRECTION - Skilled

DATE OF INSPECTION: June 1, 2, 3, and 4, 2009

STANDARD		DEFICIENCY	PLAN OF CORRECTIVE ACTION	SVH STAFF	EVIDENCE OF IMPROVEMENT	VA STAFF SIGNATURE	DATE	METHOD OF REVIEW
51.210 Administration	m. Level B Requirement Laboratory services. 1. The facility management must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	Staff reported that the glucometer being used was new. Staff was unsure if they needed to perform high/low sample tests prior to using. Some units were keeping a log of high/low sample tests and some were not. There is not consistent practice of testing the glucometer units.	Glucometer policy was reviewed and revised on 6/29/09. Nursing Staff will receive education on policy revisions on 7/30/09. Results of monitoring will be presented monthly to QA Committee.	DIRECTOR OF NURSING, Susan Peterson				
51.210 Administration	o. Clinical Records. 1. The facility management must maintain clinical records on each resident in accordance with accepted professional standards and practices that are: i. Complete; ii. Accurately documented; iii. Readily accessible; and iv. Systematically organized.-	MAR for member # 18 does not include the time of administration for the morning doses of Sennalax S BID for 4/21, 22, 23, 24, 25, 26, 27 5/1, 4, 6 Aggrenox BID 4/21, 22, 23, 25, 26, 5/1, 4, 6, Glipizide 4/21, 22, 23, 25, 26, 28, 30, 5/4, 6 and Gapapentin AM and Noon doses 4/23, 25, 26, 29, 30, 5/1, 6. MAR for member #34 does not include the time of administration for the morning doses of Potassium Chloride BID for 4/18, 20, 21, 22, 23, 25, 26, 27, 5/2, 3, 4 and the PM dose on 5/9/09. Member #16 behavior monitoring log lists fluoxetine as one of the medications ordered to target the two behaviors listed. Fluoxetine, however, is no longer an active medication. Member #6 diagnosed with OCD and prescribed paroxetine on 5/29/09. Behavior monitoring log does not reflect this diagnosis.	Medication Aides will be re-educated on 7/16/09 by the Pharmacist. QA monitor by Nursing will be completed weekly for 12 weeks then monthly for 9 months, with report to QA Committee monthly. Behavior Monitoring Logs for member # 6 and # 16 were updated. Behavior Monitoring policy was revised on 7/6/09. Education to Nursing and Social Work on 7/30/09. QA monitor by Nursing and Social Work with monthly reports to QA Committee.	PHARMACY DIRECTOR, Becky Peterson DIRECTOR OF NURSING, Susan Peterson SOCIAL WORK DIRECTOR, Dave Kreutzer DIRECTOR OF NURSING, Susan Peterson				
51.70 Resident	h. Work. The resident has the right to:	This is not met as evidenced by Member # 29 being	Member # 29 was admitted to AL/Domiciliary on 6/14/09. He	SOCIAL WORK DIRECTOR,				

Rights	i. The facility has documented the need or desire for work in the plan of care; ii. The plan specifies the nature of the services performed and whether the services are voluntary of paid; iv. The resident agrees to the work arrangement described in the plan of care.	involved in work therapy and the facility not following their policy. Work Therapy -- Member Policy dated 5-23-08 Procedure # 6 states "Prior to starting therapeutic work, the Member and work therapy supervisior will review the job descriiption and sign agreement. The work therapy supervisor will keep original agreement and give copy to Member and Member's social worker. The agreement will become part of the Member's Care Plan." Although a job description for Member #29 was found it was not signed by either the supervisor nor the member. The job description also was not found to be a part of the care plan nor was their evidence of it being reviewed quarterly by the care plan team.	and his supervisor for work therapy have signed the job description and it has been entered into his treatment plan. The Member Therapeutic Work policy was reviewed and will be revised by 7/16/09. By 7/17/09 the Director of Social Work will educate all Therapeutic Member Work Supervisors and Care Plan Team members to the revised Member Therapeutic Work Program policy. Nurses will be educated on 7/30/09. By 8/7/09 the social workers and Member Therapeutic Work Program will be fully implemented. QA monitor will be developed and implemented by 8/1/09 with monthly reports to QA by Social Work Director	Dave Kreutzer DIRECTOR OF NURSING, Susan Peterson MEDICAL DIRECTOR, Dr. Jennifer King				
51.110 Resident assessment	d. Comprehensive care plans. 1. The facility management must develop an individualized comprehensive care plan for each resident that includes measureable objectives and timetables to meet a resident's physical, mental, psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: i. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under 51.120: and	Member #30 per care plan was to wear posey hand separator and to have noodles, foam balls, etc. at all times except for hygeine. Member observed x 2 days and he did not have anything placed in his hands. Staff reports reports that splint was d/c'd due to "problems", but there was no d/c order on the chart. Member # 11 had inaccurate entry on care plan from 6/1/09 for non-pharmacological interventions to help reduce pain that included rest, PT/OT, however PT/OT d/c'd 4/28/09 due to non-compliance, no new order for PT/OT at this time. Member #10 has entry on care plan for non-pharmacological interventions for pain reduction for rest, PT/OT. Confirmed with restorative therapy that member only	Member # 30, # 11, # 10 and # 15 Care Plans were updated. Communication process was initiated by the Rehab company to email Risk Management Team weekly with list of members added or subtracted from case load beginning 7/6/09. Education to MDS Coordinators and Unit Directors on 7/7/09. All nurses will be re-educated on transcription process on 7/30/09. QA reports will be submitted monthly to QA Committee by nursing.	DIRECTOR OF NURSING, Susan Peterson				

	ii. Any services that would otherwise be required under 51.120 of this part but are not provided due to the resident's exercise of right under 51.70, including the right to refuse treatment under 51.70 (b)(4) of this part.	getting restorative. No PT/OT ordered, also hospice member so PT/OT may not be appropriate. Member #15 had PT/OT written on plan of care from 4/27/09, but it was highlighted out (possibly from order 4/29/09 to d/c PT), then PT ordered again 5/28/09 3-4 times a week. Should have been written back on care plan as active intervention.						
51.120 Quality of Care	h. Enteral Feedings. Based on the comprehensive assessment of a resident, the facility management must ensure that: 1. A resident who has been able to adequately eat or take fluids alone or with assistance is not fed by enteral feedings unless the resident's clinical condition demonstrates that use of enteral feedings were unavoidable; and 2. A Resident who is fed by enteral feedings receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, nasal-pharyngeal ulcers and other skin breakdowns, and to restore, if possible, normal eating skills.	Three members are receiving enteral feedings essential to their clinical condition. Member #28 received enteral feedings. The order is to give Jevity 1.0 cal 125cc/hour plus 25cc water for 12 hours. Member @28 is receiving Jevity 1.0 100 cc/hour plus 25 cc water for 12 hours; what is being administered is not the same as what was ordered. Member #28 has had a 34 lb (25%) weight gain since admission on 11-14-07. Member #28 is at 114 % IBW and has a diabetes diagnosis; there is no evidence of an A1C being completed. Enteral feeding is being flushed routinely with Coke after medication administration. This is no longer a recommended standard of practice and is caustic on the lining of the stomach and also to the lining of the tube when used routinely	Member # 28 did receive enteral feedings per Registered Dieticians (RD) recommendation and PHCP (Primary Health Care Provider) order dated 9/22/08. Clarification or order and entry into computer has been completed. Hbg A1C was completed on 10/09/08 and again on 5/20/09. Order for use of coke after medication administration was discontinued on 7/2/09. Member is having water flush after each dose of medication given. Re-education to nurses on 7/30/09 and to Unit Clerks on 7/21/09. Dieticians will review and document on all members receiving enteral feedings monthly. Dietary Director will monitor with reports to QA Committee monthly.	FOOD SERVICES DIRECTOR, Kathy Jensen DIRECTOR OF NURSING, Susan Peterson				
51.120 Quality of Care	M. Unnecessary drugs: 1. General. Each resident's drug regimen must be free from unnecessary drugs. An	Member #17 prescribed albuterol/ipratropium QID, per the April/May MAR, Member #17 has refused this medication 74 times. Member #17 prescribed trimethoprim/sulfamethoxaz	Member # 17 was on hospital furlough at the time of survey and continues to be hospitalized. Medical Provider will review all orders with re-admission and will discuss members refusal to take this	MEDICAL DIRECTOR, JENNIFER KING PHARMACY DIRECTOR,				

	unnecessary drug is any drug when used: i. In excessive dose (including duplicate drug therapy);or ii. For excessive duration; or iii. Without adequate monitoring; or iv. Without adequate indications for its use; or v. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or vi. Any combinations of the reasons above.	ole and nitrofurantoin for urinary prophylaxis. Medical record lacks a culture and sensitivity information for the trimethoprim/sulfamethoxazole. Member #9 prescribed trimethoprim/sulfamethoxazole Q HS even months of the year for cystitis. Culture and sensitivity indicates the E Coli found 10/2008 is resistant to this antibiotic and there is no sensitivity reported for the pseudomonas found 2/2009. Member #9 prescribed nitrofurantoin Q HS odd months of the year for cystitis. Culture and sensitivity indicated the E Coli found 10/2008 is intermediate to this antibiotic and there is no sensitivity reported for the pseudomonas found 2/2009. Additionally, memebers renal funtion is 46ml/min. Use of this medication in CrCl < 60ml/min is contraindicated by the FDA. Member #22 prescribed lantus, insulin 70/30 and glipizide. According to the 2009 American Diabetes Association Consensus Satement sulfonylurea therapy should be discontinued when insulin is started since they are not considered to be synergistic. Member #23 prescribed epoetin alpha once weekly and darbepoetin alpha once weekly. Lab indicates that HGB was 12.9 g/dL 4/22/09 and 15 g/dL 5/15/09. MAR indicates both of these injections were administered weekly 4/22/09 through 5/27/09. Both injections cary a black box warning by the FDA due to an increased risk of death and serious cardiovascular events in	particular medication at that time. Medication Aides will be re-educated to Medication Administration Policy on 7/16/09 and education to nurses on 7/30/09. Infection Control Committee will review all members on chronic antibiotic prophylaxis for suppressive therapy. Suppressive therapy will be monitored via Drug Regimen Review (DRR). Medical staff and pharmacy education will be performed 7/16/09. Query was completed 7/6/09 to review all members on sulfonylureas and insulin therapy and adjustments will be made by Primary Health Care Provider (PHCP) as appropriate by 7/14/09. This will continue to be monitored by DRR. Medical staff and pharmacy education will be performed 7/16/09. Query was completed 6/22/09 to review all members on macrodantin to ensure adequate creatinine clearance and adjustments were completed by PHCP as appropriate by 7/2/09. This will continue to be monitored by DRR. Medical staff and pharmacy education will be performed 7/16/09. Protocol template for epogen/aranesp usage will be completed by 7/9/09. Medical staff and pharmacy education will be performed 7/16/09 and protocol will be implemented 7/17/09. DRR will continue to monitor usage. Pharmacy will automatically forward all black box warnings and advisories to medical staff. LB195 will allow each individual facility to establish	Becky Peterson DIRECTOR OF NURSING, Susan Peterson				

		patients with chronic renal failure when dosed to target higher hemoglobin levels. Dosing should be individualized to achieve and maintain hemoglobin levels within 10-12g/dL range. Member #16 prescribed risperdal BID PRN. MAR and pharmacy drug regimen review indicate that this has not been utilized but remains an active order. Member #16 prescribed baclofen QID. MAR indicates that the PM dose was refused 31 times during the month of May.	their own emergency box as of 9/1/09. This will allow us to have appropriate anti-psychotics available for emergent usage and eliminate the need for most PRN anti-psychotics. The GIVH emergency box list will be established by 8/7/09 but not be able to implement until 9/1/09 due to legislation. DRR results related to the Plan of Correction will be reported monthly to QA by Pharmacy Director.					
51.120 Quality of Care	n. Medication Errors. The facility management must ensure that: 1. Medication errors are identified and reviewed on a timely basis; and 2. Strategies for preventing medication errors and adverse reactions are implemented	Surveyor observed staff member #6 giving astelin nasal spray to member on 6/2/09, however order was for medication to be stopped 6/1/09. Drug was still in member's med drawer and order was not highlighted out on MAR thus both contributing to med error on observation date. Surveyor observed staff member # 1 passing medications 6/1/09. Order for Lanoxin 1/2 tab 0.125 mg. In medication cassette was a whole pill. This staff member did not give the pill, sent cassette back to pharmacy for correction, however 3 days prior to this date pills were missing from cassette, thus med errors occurred 3 days prior to observation date. Noted throughout facility and as evidenced by these 2 examples: Member # 11 order for lisinopril 10 mg 1 daily for BP staff to call MD if BP >180/100 or 2 BP in 30 days >140/90. Staff members are not taking BP at time of medication administration. Member # 10 order for monopril 10 mg daily, call if	Staff involved received education on 6/2/09 with Med Error report documentation. All Medication Aides will receive Competency Reviews monthly. Education to all Medication Aides on 7/16/09. Monthly audit with report by nursing to QA Committee. Pharmacists will be educated on the Cart Fill Check process by 8/1/09. Medication Errors will continue to be monitored by Pharmacy Oversight Committee with report to QA Committee. Pharmacy will remove BP/Pulse Recommendation by 8/1/09 on all cassettes, orders, and default parameters on the drug file.	PHARMACY DIRECTOR, Becky Peterson DIRECTOR OF NURSING, Susan Peterson				

		BP >180/100 or 2 BP in 30 days > than 140/90. Staff members are not taking BP at time of medication administration. Member 33 has an order for Lisinopril 10 mg in the morning. Call if Blood pressure is over 180/100 or two Blood Pressures are over 140/90. Staff does not take blood Pressures prior to medication administration.						
51.180 Pharmacy Services	a. Procedures. The facility management must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	Eight prescrptions dated 5/20/2009 to 5/22/09 for controlled substances, schedule II, dispensed for member use without medical provider signature on the hard copy of the prescription that is required by law.	All prescriptions in question at survey now have physician signatures. Pharmacists will be educated on procedure to handle Schedule II prescription by 7/15/09. Process will be monitored weekly for 3 months and then monthly with reports to QA Committee by Pharmacy Director.	PHARMACY DIRECTOR, Becky Peterson				
51.180 Pharmacy Services	b 2. Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and; b 3. Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	Perpetual inventory for controlled substances contains five discrepancies. Morphine20mg/mL: Expected 90ml, found 60mL. Oxycontin 40mg: Expected 330, found 270 Testosterone Enanthate 200mg/mL 5mL vial: Expected 5.5mL, found one 5ml vial with < 1mL that expired 4/2009 but remains in dispensible stock. Testosterone Cypionate 200mg/mL: Expected 0mL, found 10mL Fentanyl 25mcg Patch: Expected 130, found 125.	Discrepancies noted at survey have all been reconciled. Expired stock has been returned for credit. Pharmacists and staff were educated 6/3/09, that loaning controlled substance in Schedules III, IV, and V is not permitted, and educated in the process to reconcile narcotics by 8/1/09. Perpetual Inventory will be reconciled monthly by 2 staff members, at least one being a pharmacist. Completion of process will be monitored and reported monthly to the QA Committee by Pharmacy Director.	PHARMACY DIRECTOR, Becky Peterson				
51.180 Pharmacy Services	c. Drug regimen review 1. The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	16 of 17 records reviewed do not contain a monthly drug regimen review completed by a licensed pharmacist for each of the past 12 months.	A pharmacist was hired to complete these reviews with compliance since 3/09. Monitoring will occur monthly with report to QA by Pharmacy Director. Reviews not completed will be reported to	PHARMACY DIRECTOR, Becky Peterson				

			the Director of Nursing with reasons for any incomplete reviews.					
51.180 Pharmacy Services	d. Labeling of drugs and biological. Drugs and biologicals used in the facility management must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	Five vials of ceftriaxone not dated when opened and reconstituted by pharmacy.	Procedure for reconstituting medications including instructions to label all medications with expiration dates and storage requirements before dispensing to floor will be educated to all pharmacy staff by 8/1/09. Monitoring of this procedure is done monthly by Pharmacy Director with report to QA Committee.	PHARMACY DIRECTOR, Becky Peterson	.			
51.190 Infection Control	The facility management must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.	On 6/1/09 WWII east bath house had 4 roll-on deoderants used but not marked with individual names, 1 disposable razor used but not marked with members name and 1 shampoo not marked with members name. These items discarded. On 6/1/09 room 202 nebulizer mask not dated or labeled. On 6/1/09 WWIII west bath house had 2 roll-on deoderants used but not marked with individual names, items disposed of. On 6/2/09 noted 1 nebulizer mask not dated or labeled. 6/1/09 Baskets containing personal care items for members were dirty (Anderson Building) 6/1/09 In Anderson Building, drinking cups used for hydration were stored uncovered. 6/3/09 Shampoo and ointments for various members were stored in the same container in the Anderson Building bath house. There was no separation of personal care items. Member #8 is MRSA Positive in Nares. The	Bath aides on all units will be responsible to monitor and mark all personal care bathing items. Education was presented by Infection Control Nurse to bath aides and other Direct Care Staff on all units by 7/10/09. Infection control nurse will monitor for compliance monthly with report to QA. Process has been adjusted and all nebulizer masks, O2 tubing and cannulas will now be marked by Restorative Aide. Restorative Nurse will monitor and report to QA Committee monthly. Routine cleaning of closet and drawers is assigned weekly to a specific staff person for each member. Ointments, shampoos, and other personal care items will be kept in individual bins in a locked cupboard in each bathhouse. Infection control nurse will monitor monthly and report to QA Committee. Policy for cleaning and maintenance of respiratory	INFECTION CONTROL NURSE, Rhonda Sherman DIRECTOR OF NURSING, Susan Peterson				

		CPAP equipment for this Veteran is being brought out and stored in a clean holding area. There was no identified way to clean the CPAP Unit and Staff gave various answers when asked what was being done.	equipment was revised on 7/6/09. Education will be provided to nurses on 7/30/09. Infection Control Nurse will monitor monthly with report to QA Committee.					

Did the SVH submit CAP within 10 days? _____Yes _____No

Approve / Disapprove

Full Certification Provisional Certification

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51.120 M. Unnecessary Drug Usage

Drug regimen reviews are current. July drug regimen reviews specifically address non-use of prn medications and if medications are not being used, providers are being notified and appropriate orders written. These will be completed by July 31, 2009.